SUMMARY OF BENEFITS CIGNA Health and Life Insurance Co.

Fermi Research Alliance, LLC
Network Point of Service

Notice of Grandfathered Plan Status
This plan is being treated as a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the phone number or address provided in your plan documents, to your employer or plan sponsor or an explanation can be found on CIGNA's website at http://www.cigna.com/sites/healthcare_reform/customer.html.

If your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.
If your plan is a nonfederal government plan or a church plan, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Annual deductibles and maximums	In-network	Out-of-network
Lifetime maximum	Unlimited per individual	
Pre-Existing Condition Limitation (PCL)	Not Applicable	
Coinsurance • All services will be covered at 100% coinsurance level, with or without applicable copays, except for Rx which can be subject to coinsurance.	No charge	You pay 30%

Maximum reimbursable charge
• Determined based on the lesser of:
  • the health care professional's normal charge for a similar service; or
  • a percentile of the amount charged by health care professionals in the geographic area where the service is received.
• Out-of-network services are subject to a calendar year deductible and maximum reimbursable charge limitations.
	N/A	80th percentile

Calendar year deductible • Deductible is calculated on a calendar year basis. • After each family member meets his or her individual deductible, the plan will pay his or her claims, less any coinsurance amount. After the family deductible has been met, each individual's claims will be paid by the plan, less any coinsurance amount	**Employee** $0 **Employee and family** $0	**Employee** $350 **Employee and family** $1,050
Calendar year out-of-pocket maximum • The amount you pay for any deductible only applies to either network or non-network in which it was incurred. • Out-of-Network: Expenses that count towards your out-of-pocket maximum include member paid coinsurance. . Other deductibles, inpatient facility and outpatient facility copays, non-compliance penalties or charges in excess of	**Employee** $0 **Employee and family** $0	**Employee** $3,000 excludes deductible **Employee and family** $6,000 excludes deductible

Annual deductibles and maximums	In-network	Out-of-network
Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum. • Out-of-Nework expenses that do not contribute towards your out-of-pocket maximum includes non-compliance penalties and charges in excess of Reasonable and Customary. • Mental health and substance abuse services count towards your out-of-pocket maximum. • Copays not listed above and plan deductibles do not count towards your out-of-pocket maximum		

Benefits	In-network	Out-of-network
Physician services		
Office visit • Specialist copay applies to OB/GYN physician	**Primary care physician** You pay $20 per visit **Specialist** You pay $30 per visit	You pay 30% Plan pays 70% after the deductible is met
Allergy treatment services **Allergy Serum (dispensed by physician in office)**	**Primary care physician** You pay $20 per visit **Specialist** You pay $30 per visit No charge	You pay 30% Plan pays 70% after the deductible is met
Physician services (hospital) • In hospital visits and consultations • Inpatient • Outpatient	**Inpatient and outpatient services** No Charge	You pay 30% Plan pays 70% after the deductible is met
Surgery (in a physician's office)	**Primary care physician** You pay $20 per visit **Specialist** You pay $30 per visit	You pay 30% Plan pays 70% per visit after the deductible is met
Preventive care		
Routine preventive care • Includes well-baby, well-child, well-woman and adult preventive care • Immunizations are covered at no charge. • Specialist copay applies to OB/GYN physician	**Primary care physician** You pay $20 per visit **Specialist** You pay $30 per visit	Not covered

Benefits	In-network	Out-of-network
Mammogram, PSA, Pap Smear • Includes charges for the procedure itself and the professional reading charge. • The associated wellness exam is subject to the PCP or Specialist per office visit copay. • The associated wellness exam is not covered for out-of-network.	No charge	You pay 30% Plan pays 70% after the deductible is met
Inpatient hospital facility services		
Semi-private room and board and other non-physician services • Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc.	$200 copay per admission, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met
Inpatient Professional Services • For services performed by surgeons, radiologists, pathologists and anesthesiologists	No charge	You pay 30% Plan pays 70% after the deductible is met
Multiple surgical reduction • Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.	Not applicable	Included
Outpatient services		
Outpatient surgery (facility charges) • Non-surgical treatment procedures are not subject to the facility copay.	$100 copay per admission, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met
Outpatient Professional Services • For services performed by surgeons, radiologists, pathologists and anesthesiologists	No charge	You pay 30% Plan pays 70% after the deductible is met
Physical, occupational, cognitive and speech therapy • Maximum of 60 days per calendar year for all therapies combined • Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy • Includes chiropractic therapy (Includes chiropractors) • Includes cardiac rehabilitation • Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehab therapy maximum.	**Primary care physician** You pay $20 per visit **Specialist** You pay $30 per visit	You pay 30% Plan pays 70% after the deductible is met
Lab and X-ray		
Lab and X-ray • Physician's office • Independent lab facility	No charge	You pay 30% Plan pays 70% after deductible is met

Benefits	In-network	Out-of-network
Lab and X-ray • Outpatient hospital facility	No charge No charge for outpatient professional services	You pay 30% Plan pays 70% after deductible is met
Lab and X-ray • Independent x-ray and/or lab facility as part of an ER visit	No charge	No charge
Advanced radiological imaging • MRI, MRA, CAT Scan, PET Scan, etc. • Inpatient facility	No charge	You pay 30% Plan pays 70% after the deductible is met
Advanced radiological imaging • MRI, MRA, CAT Scan, PET Scan, etc. • Outpatient facility	No charge	You pay 30% Plan pays 70% after the deductible is met
Advanced radiological imaging • MRI, MRA, CAT Scan, PET Scan, etc. • Emergency room	No charge	No charge
Advanced radiological imaging • MRI, MRA, CAT Scan, PET Scan, etc. • Physician's office	No charge	You pay 30% Plan pays 70% after the deductible is met
Emergency and urgent care services		
Hospital emergency room • Includes radiology, pathology and physician charges • Copay waived if admitted • Out-of-network services are covered at the in-network rate.	No charge after $100 per visit copay	
Ambulance • Out-of-network services are covered at the in-network rate if it is a true emergency. If it is not a true emergency, the out-of-network rate is charged.	No charge	You pay 30% Plan pays 70% after the deductible is met
Urgent care services • Copay waived if admitted. • Out-of-network services are covered at the in-network rate.	No charge after $100 per visit copay	
Other health care facilities		
Skilled nursing facility, rehabilitation hospital and other facilities • 60 days per calendar year combined	No charge	You pay 30% Plan pays 70% after the deductible is met
Home health care • 60 days per calendar year *Includes outpatient private duty nursing when approved as medically necessary,* 16 hour maximum per day	No charge	You pay 30% Plan pays 70% after the deductible is met
Hospice Inpatient services Outpatient services	No charge	You pay 30% Plan pays 70% after the deductible is met

Benefits	In-network	Out-of-network
Other health care services		
Durable medical equipment • Unlimited calendar year maximum • Out-of-network charges only count towards your out-of-network maximum.	No charge	You pay 30% Plan pays 70% after the deductible is met
External prosthetic appliances (EPA) • There is a $200 calendar year EPA deductible. • Unlimited calendar year maximum	No charge after the $200 EPA deductible is met	You pay 30% Plan pays 70% after the EPA and medical plan deductibles are met
TMJ, surgical and non-surgical • Excludes appliances and orthodontic treatment • Physician's office • Inpatient facility • Outpatient facility • Physician's services		
• Physician's office	**Primary care physician** You pay $20 per visit **Specialist** You pay $30 per visit	You pay 30% Plan pays 70% after the deductible is met
• Inpatient & Outpatient hospital facility	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
• Independent x-ray and/or lab facility	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Infertility • Office visit for testing, treatment and artificial insemination. • Inpatient hospital facility • Outpatient hospital facility • Physician services • Surgical treatment includes both correction and in-vitro fertilization, GIFT, ZIFT, etc.		
• Physician's office	**Primary care physician** You pay $20 per visit **Specialist** You pay $30 per visit	You pay 30% Plan pays 70% after the deductible is met
• Inpatient & Outpatient hospital facility	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
• Independent x-ray and/or lab facility	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met

Benefits	In-network	Out-of-network
Family planning • Office visits • Inpatient hospital facility • Outpatient facility • Physician services • Surgical services such as tubal ligation or vasectomy are covered (excluding reversals).		
• Physician's office	**Primary care physician** You pay $20 per visit **Specialist** You pay $30 per visit	You pay 30% Plan pays 70% after the deductible is met
• Inpatient & Outpatient hospital facility	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
• Independent x-ray and/or lab facility	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Mental health and substance abuse services		
Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration: Substance Abuse includes Alcohol and Drug Abuse services. Transition of Care benefits are provided for a 90-day time period.		
Inpatient mental health services • Unlimited days per calendar year • Mental health services are paid at 100% after you reach your out-of-pocket maximum.	$200 copay per admission, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the medical plan deductible is met
Outpatient mental health physician's office services • Unlimited visits per calendar year • Mental health and substance abuse services are paid at 100% after you reach your out-of-pocket maximum. • This includes group therapy mental health and intensive outpatient mental health	You pay $30 per visit	You pay 30% Plan pays 70% after the medical plan deductible is met
Inpatient substance abuse services • Unlimited days per calendar year • Substance abuse services are paid at 100% after you reach your out-of-pocket maximum.	$200 copay per admission, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the medical plan deductible is met
Outpatient substance abuse physician's office services • Unlimited visits per calendar year • Mental health and substance abuse services are paid at 100% after you reach your out-of-pocket maximum. • This includes intensive outpatient substance abuse	You pay $30 per visit	You pay 30% Plan pays 70% after the medical plan deductible is met

Benefits	In-network	Out-of-network
Prescription drugs		
CIGNA Pharmacy three-tier copay plan • Generic push– the most cost-effective option. • Self administered injectable–includes infertility drugs • Includes Oral Contraceptives • Lifestyle drugs – limited to sexual dysfunction • Oral fertility drugs included	**Retail** **At an in network Pharmacy** (30 day supply) You pay: Generic $10 Preferred Brand $20 Non-Preferred Brand $40 **Home Delivery** **At CIGNA Home Delivery** (90 day supply) You pay: Generic $20 Preferred Brand $40 Non-Preferred Brand $80	You pay 30% Plan pays 70% after the deductible is met Not Covered
Pharmacy Deductible (Individual/Family)	None	$50 per individual/ None per family
Specialty Pharmacy • Clinical Programs	Prior authorization required on specialty medications and quantity limits may apply.	
Specialty Pharmacy • Medication Access Option	Retail and/or Home Delivery	
Vision care • Eye exam every 24 months • Eye glasses and contact lenses are not covered. • At an in network Vision Service Plan provider	$10 copay per office visit	

Definitions

Deductible – A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

Coinsurance – After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called coinsurance.

Copay – A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

Out-of-pocket Maximum – Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "maximum reimbursable charges" or negotiated fees for covered services.

Place of service – Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

Selection of a Primary Care Provider – Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, CIGNA may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

Direct Access to Obstetricians and Gynecologists – You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Maximizing your health care dollars

Log on to myCIGNA.com for resources to help you choose a health care professional or compare the cost and quality of medical services, medications and hospital care.

When you need a medical service or procedure, CIGNA offers you opportunities to save on prescription medicine, routine medical care, laboratory services, radiology scans, and outpatient surgery. Details are below:

CIGNA Home Delivery Pharmacy –You can save money and enjoy convenient home delivery by using CIGNA Home Delivery Pharmacy for your prescription medications. You can get up to a 90-day supply of your medication.

Lab – Save on lab services by using a free-standing laboratory instead of a hospital- or clinic-based lab.

Urgent Care – For non-emergency conditions that need attention before you can see your doctor, you can save money by going to an urgent care center instead of an Emergency Room (ER).

Convenience Care – For minor or routine conditions, go to a Convenience Care Clinic when your doctor is unavailable. Convenience Care Clinics are retail-based and often found in pharmacies or grocery stores.

Radiology – Costs for MRIs, PET, and CT scans can vary greatly. Non-hospital based outpatient radiology centers often cost much less than a hospital. CIGNA's network includes both hospitals and outpatient centers, so you can find a radiology center that's right for you.

Outpatient Surgery – Costs for colonoscopies, arthroscopies, and other outpatient procedures can vary greatly. Using a free-standing outpatient surgery center can save hundreds of dollars.

Exclusions

What's Not Covered (*not all-inclusive*):

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law, include (but aren't limited to):

- Services provided through government programs
- Services that aren't medically necessary
- Experimental, investigational or unproven services
- Services for an injury or illness that occurs while working for pay or profit including services covered by worker's compensation benefits
- Cosmetic services
- Dental care, unless due to accidental injury to sound natural teeth
- Reversal of sterilization procedures
- Genetic screenings
- Non-prescription and anti-obesity drugs
- Custodial and other non-skilled services
- Weight loss programs
- Hearing aids
- Acupuncture
- Travel immunizations
- Telephone, email and internet consultations in the absence of a specific benefit
- Surgical vision correction

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

Additional Information

Additional benefit information	In-network	Out-of-network
Pre-admission certification – continued stay review (PHS+) • Benefits are denied for any admission reviewed by CIGNA Healthcare and not certified. • Benefits are denied for any additional days not certified by CIGNA Healthcare. • Benefits are denied for any outpatient procedures/diagnostic testing reviewed by CIGNA Healthcare and not certified.	Inpatient Pre-Admission Certification - Coordinated by provider/PCP Outpatient Prior Authorization – Coordinated by provider/PCP	Employee is responsible for contacting CIGNA Healthcare. A 50% penalty is applied to hospital inpatient charges and/or outpatient procedures/diagnostic testing for failure to contact CIGNA Healthcare to pre-certify admission
Case management	Coordinated by CIGNA HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.	
Mental health/Substance abuse utilization review, case management and programs	Capitation (CAP) - Inpatient and Outpatient Management • Case Management and Utilization Review for Inpatient Services (In-Network, Out of Network) and Outpatient Services (In-Network only) Provided by CIGNA Behavioral Health (CBH). • Includes Lifestyle Management Programs: Stress management & Tobacco Cessation, Healthy Steps to Weight Loss.)	
MH/SA Service Specific Administration	Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs: • *Partial Hospitalization:* The coinsurance level for partial hospitalization services is the same as the coinsurance level for inpatient MH/SA services. • *Standard for Residential Treatment:* Subject to the plan's inpatient MH/SA benefit. Coverage only if approved through CIGNA Behavioral Health Case Management. • *Intensive Outpatient Program (IOP):* Benefit is the same as outpatient visits. Coverage only if approved through CIGNA Behavioral Health Case Management.	
Bereavement counseling - inpatient services	No charge	Not covered
Bereavement counseling – outpatient services	No charge	Not covered
Maternity care services • Federal legislation maternity - employee, all dependents • Pre-natal visits, post-natal visits and physician's delivery charges are subject to medical coinsurance and deductible	Cost and reimbursement vary based on the facility in which it is performed	Cost and reimbursement vary based on the facility in which it is performed
Abortion • Provides elective coverage	Cost and reimbursement vary based on the facility in which it is performed	Cost and reimbursement vary based on the facility in which it is performed

Additional benefit information	In-network	Out-of-network
Organ transplant • Inpatient Hospital same as plan's inpatient hospital facility • Travel maximum $10,000 per transplant (only available if using Lifesource facility)	Cost and reimbursement vary based on the facility in which it is performed	Not covered
Dental care • Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth	Cost and reimbursement vary based on the facility in which it is performed	Cost and reimbursement vary based on the facility in which it is performed.
Bariatric surgery • Subject to medical necessity and clinical guidelines • Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered only at approved centers. • The following are excluded: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • The following are excluded: weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.	Cost and reimbursement vary based on the facility in which it is performed	Not covered
Routine foot disorders • Not covered, except for services associated with foot care for diabetes and peripheral vascular disease when medically necessary.	Not covered	Not covered
Included Health and Wellness Programs		
Well Aware program for better health • Diabetes • Cardiac • Asthma • Low back pain • COPD – Chronic Obstructive Pulmonary Disease • Weight complications • Depression • Targeted conditions	Included	
Lifestyle Management Programs - included with CIGNA Behavioral Advantage • Weight Management • Tobacco Cessation • Stress Management		

Exclusions

What's Not Covered (*not all-inclusive*):
Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an illness or injury which is due to war, declared or undeclared.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of "Covered Services and Supplies;" or The subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of "Covered Services and Supplies."
- Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
- Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Covered Services and Supplies."
- Reversal of male and female voluntary sterilization procedures.
- Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
- Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job,

Exclusions

school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of "Covered Services and Supplies."
- Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of "Covered Services and Supplies".
- Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
- Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Covered Services and Supplies."
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
- Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Agreement as a retiree, or his Dependents, when payment is denied by the Medicare plan because treatment was not received from a Participating Provider of the Medicare plan.
- Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan.
- Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail & Internet consultations and telemedicine.
- Massage Therapy

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.